Davis AUDIOLOGY
Hear your world.

Name of Child: _____ Name of Parent_____

DOB: _____Today's Date: _____Name of Pediatrician: _____

GENERAL INFORMATION:

What is your primary Concern? _____

When did you first notice the problem? _____

Has your child's hearing been tested before? Yes___ No___**If yes what were the results? _____**

_____

HEALTH HISTORY:

Is your child adopted? Yes___ No___

Were there any problems during pregnancy? Yes___ No___**If yes please explain?_____**

_____

Was your baby full term? Yes___ No___**What was your baby's birth weight? _____**

Were there any problems during delivery or after the birth of your child? Yes___ No___**If yes please explain?_____**

Were any medications taken during the pregnancy or while breast-feeding? Yes___ No___**If yes please describe?_____**

Has your child had bacterial meningitis or any other infections? Yes___ No___**If yes please explain?**

_____

Has your child had any head trauma, loss of consciousness, or skull fractures? Yes___ No___**If yes please explain? _____**

Has your child had repeated ear infections? Yes___ No___

Has your child ever had pressure equalization tubes? Yes___ No___

Does your child take medication regularly? Yes___ No___**If yes please explain?_____**

_____

Does your child have any allergies? Yes___ No___

Does anyone in your family have hearing loss or speech problem? Yes___ No___**If yes what is their relation?_____**

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Your child's general health is? Excellent_____ Good_____ Fair_____ Poor_____

DEVELOPMENTAL HISTORY:

If your child is under 10 years old:

At what age did your child speak his/her first words? _____ first sentence? _____

Does your child like to read? Yes___ No___

Do you feel your child's speech is readily understandable by others? Yes___ No___

Has your child recently changed behavior at home and/or experienced any major life changes?

Primary language spoken at home? _____

Please check all that apply; My child responds appropriately to:

○	Name	○	The direction sounds come from
○	Favorite TV program/movie	○	Questions
○	Commands/requests	○	Startle to sound while resting

Please check all that apply; My child has been diagnosed with:

○	Attention Deficit Disorder	○	Muscular Dystrophy
○	Mental Retardation	○	Speech/Language Delay
○	Down's Syndrome	○	Learning Disability
○	Autism	○	Cerebral Palsy
○	Vision problems	○	Other(please explain)

EDUCATION/AMPLIFICATION HISTORY:

School name? _____ Grade? _____

Has your child ever repeated a grade? Yes___ No___

Has your child been placed in Special Education? Yes___ No___

Has your child received hearing/speech/language services? Yes___ No___

Has your child ever used a hearing aid? Yes___ No___

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AUTHORIZATION FOR RELEASE OF INFORMATION

I do hereby authorize Davis Audiology, LLC to **furnish and/or to obtain** information concerning

_____with respect to *patient's physicians and*
Patient Name

manufacturers.

1. Primary Care Physician's Name: _____

2. _____

AUTHORIZATION FOR TELEHEALTH SERVICES AND OR USE OR DISCLOSURE OF PATIENT PHOTOGRAPHIC AND OR VIDEO IMAGES

Telehealth allows a hearing care provider to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment.

☐ I hereby consent to participating in hearing care via Telehealth. I understand that confidentiality with Telehealth is under the same laws that protect the confidentiality of my medical information for in-person treatment. I authorize the use and disclosure of my photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA privacy regulations.

☐ I do not wish to participate in Telehealth.

☐ I do not authorize the disclosure of photographic/video images for marketing/testimonial purposes.

Signature_____Date_____

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ASSIGNMENT OF INSURANCE BENEFITS

Patients with *insurance* please read and sign below:

Davis Audiology is happy to process your insurance claim for professional services received; however, your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims or accept responsibility for negotiating claims with your insurance company. Charges not paid by your insurance company for professional services rendered such as a diagnostic hearing examination are ultimately the responsibility of the patient. At Davis Audiology patients receive a diagnostic hearing examination performed by a licensed Doctor of Audiology. This is the only way to get a proper and comprehensive assessment of a patient's hearing. This examination is not simply for the purpose of hearing loss related to the purchase of hearing aids. A Doctor of Audiology also has the professional responsibility to look for and rule out other hearing health care conditions/pathologies related to the ear such as; middle ear fluid, ear disease, and either nerve tumors to name a few.
As credentialed Medicare healthcare providers, the Doctors of Audiology at Davis Audiology are required by federal law to charge all patients for their diagnostic hearing examinations. It is unlawful for the Doctors of Audiology at Davis Audiology as Medicare provider to provide a service for free to other patients that is reimbursed by Medicare. Medicare legally requires its providers to treat everyone the same That means a Medicare provider cannot choose to charge some patients for the services they provide and then not charge others for the same service. I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans to Davis Audiology. A photocopy of my insurance card (assignment) and a copy of my driver's license are to be considered as valid as an original.

I am financially responsible for all charges whether or not paid by the above insurance. I hereby authorize Davis Audiology to release all information necessary to secure the payment. ***If insurance pays only a portion of the bill or fails to make payment to Davis Audiology within 90 days, I will be responsible for payment of balance in full at that time.*** **Please Note: A copy of your most current insurance card is required to process your visit to insurance if applicable. Failure to provide this may result in Davis Audiology's inability to file your insurance claim for you, if applicable.**

_____ _____

Signature Date

MEDICARE PATIENTS:

I request payment of authorized Medicare benefits to be made to Davis Audiology for any services rendered. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or related services to pay the claim. If there are other insurance carriers, my signature authorizes releasing of information. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge ***and the patient is responsible for only the deductible, coinsurance and the non-covered services. Coinsurance and the deductible are based upon the charge determined by the Medicare carrier.***

_____ _____

Signature Date

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Patient Financial Responsibility Statement

We ask that you please read and understand your financial responsibilities prior to receiving services.

Financial Information:

1. I understand that I am financially responsible for all charges not paid by insurance. I authorize the release of information to my insurance company for insurance/medical purposes. I hereby authorize payment from my insurance company to Greer Audiology LLC (dba Davis Audiology).
2. I understand that I am solely responsible for obtaining any necessary referrals and/or authorizations prior to my appointment.
3. I understand that if I do not have valid medical insurance, I am financially responsible for all fees at the time services are rendered. **Please Note: A copy of your most current insurance card is required to process your visit to insurance if applicable. Failure to provide this may result in Davis Audiology's inability to file your insurance claim for you, if applicable.**
4. I understand that I am expected to pay all copays, coinsurance, and deductibles at time of service.
5. I understand I will be charged $30 for any check returned by my bank for any reason.
6. I understand it is my responsibility to inform Davis Audiology if my insurance has changed.

No Show and Late Cancellation Policy:

It is the policy of the practice to monitor and manage appointment no-shows and late cancellations. Davis Audiology's goal is to provide excellent and timely care to each patient. If it is necessary to cancel an appointment, patients are required to call or leave a message at least 24 business hours prior to the scheduled appointment time. Patients will be assessed a fee of $25 for each documented no show or late cancellation. Notifying our practice in a timely manner allows our providers to better utilize appointments for other patients in need of hearing healthcare. In the event a patient has incurred three (3) documented "no-shows" or "late cancellations" within 1 year, the patient may be subject to dismissal from Davis Audiology. Dismissals are determined by the owner after the patient's chart has been reviewed.

The charge for late cancellation/no-show of appointments will be billed directly to you and not to your insurance. We understand that situations such as medical emergencies occasionally arise. These situations will be considered on a case-by-case basis.

By signing below, I acknowledge that I understand and agree to these terms:

_____ _____

Signature Date

_____ _____

Print Date of Birth

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MEDICAID STATEMENT OF NON-PAYMENT

I, _____, acknowledge the fact that I have been informed that Davis Audiology is not contracted with Medicaid. Therefore, I am responsible for any balances not paid by my primary insurance carrier.

We have estimated your portion for your visit to be _____ for your visit on _____. This is an estimate and may not be the total that would be owed by you. By signing below you acknowledge that you will be financially responsible for any unpaid balance by your primary carrier. If you have any questions, please give our office a call at 864-655-8300.

_____ _____

Patient Signature Date

_____ _____

Staff Signature Date

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Acknowledgement of Receipt of Privacy Notice

I hereby acknowledge that I reviewed a copy of Davis Audiology's Notice of Privacy Practices.

Signature: _____ Date: _____

If not signed by the patient, please indicate relationship: _____

Disclosure of Medical Information

Your medical information and communication of that information is essential to your care. We prefer to speak directly with each patient but we understand that other individuals or family members may have knowledge of and may be assisting in your care. **Please list the individuals who we are authorized to discuss your care with.** (Note: We cannot discuss your care with others, including your spouse or other family members living with you, unless they are listed below.)

Name of person: _____ Relationship to Patient: _____

Name of person: _____ Relationship to Patient: _____

Name of person: _____ Relationship to Patient: _____

Confidential Communications between Office and Patients

I authorize communications by Davis Audiology concerning scheduled appointments, treatment, practice information and newsletters through the following methods:

Please select all that apply: ☐ Call ☐ Text ☐ Work ☐ Email

Home Phone: (_____) _____-_____ Authorize messages? ☐ Yes ☐No

Cell Phone: (_____) _____-_____ Authorize messages? ☐ Yes ☐No

Work Phone: (_____) _____-_____ Authorize messages? ☐ Yes ☐No

Email: _____

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What is your preferred method for *appointment reminders*?

☐ Call ☐ Text ☐ Work ☐ Email